

*Passport Health of Upstate NY*  
University of Rochester School of Nursing  
601 Elmwood Avenue, Box SON  
Rochester, NY 14642  
Phone: (585) 275-8884 Fax: (585) 276-2089



## Authorization for Release of Medical Information

**Patient's name:**

**Date of Birth:**

**Address:**

**Patient's phone#:**

**City/State/Zip**

**Last four digits of SS#**

**PURPOSE FOR THIS REQUEST:**  Healthcare / Appointment: **date** \_\_\_\_\_

**This Authorization allows URM/Strong Health to: (check ONE)**

**SEND** copies of your record to (or discuss your information with) the provider/person/facility below

**OR**

**RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

Name of Provider / Person / Facility Address

City, State, Zip Code Phone #/Fax # (include area code)

**TYPE OF RECORDS / INFORMATION REQUESTED: Check all that apply:**

Vaccination History to date: Including Date(s) and Type of vaccine

**AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)**

This request only

One year from the date of this authorization **OR** \_\_\_\_\_ (insert date). This authorization applies to the

records of the treatment received on or prior to the date of this authorization.

This request **and** for medical records of any **future** treatment of the type described above until: \_\_\_\_\_ (insert date).

**I understand that:**

My right to healthcare treatment is not conditioned on this authorization.

I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.

If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed; except that records protected by Federal Confidentiality Rules 42CR, Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.

Release of HIV-related information requires additional authorization.

There may be a charge for the requested records.

The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient (*if Representative*) \_\_\_\_\_